

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11953

CERTIFICATE OF DEATH

11962

Reg. Dist. No.

181

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 622 Walker	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle A. Last Baldwin		4. DATE OF DEATH Month November Day 3 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 March 1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Silas Baldwin		14. MOTHER'S MAIDEN NAME Susan Lee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -- -- --	
17. INFORMANT Robert L. Schofield		Address Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 yrs. (c) 5 days		INTERVAL BETWEEN ONSET AND DEATH 5 days 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Bladder		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-29-57 to 11-3-57 , that I last saw the deceased alive on 11-2-57 , 19 57 , and that death occurred at 3:24 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Chardon, Md.	
ACTUAL SIGNATURE Peter P. Rodman, M.D.		DATE SIGNED 11-4-57	
PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/6/57	22c. NAME OF CEMETERY OR CREMATORY Smith Chapel Cemetery	22d. LOCATION (City, town, or county) (State) R.D. 2, Aberdeen, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John S. Lanning		ADDRESS Aberdeen, Md.	
24a. REC'D BY REGISTRAR DATE 11-5-57		24b. REGISTRAR'S SIGNATURE Walter R. Perry	

BUREAU Y. E.

NOV 7 1957

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Name of Deceased		Date of Death	
John A. Smith		November 1, 1957	
Age		35	
Sex		Male	
Race		White	
Marital Status		Married	
Usual Residence		Baltimore, Maryland	
Cause of Death		Heart Disease	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11969

CERTIFICATE OF DEATH

11963

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STREET</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 yrs</u> <u>X2 STREET R.D.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>COLE</u> Last <u>BLANEY</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>1st</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10-1921</u>
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months <u>36</u> Days <u>36</u> Hours <u>36</u> Min. <u>36</u>	IF UNDER 24 HRS. Months <u>36</u> Days <u>36</u> Hours <u>36</u> Min. <u>36</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WELSH CONSTRUCTION CO</u>	
11. BIRTHPLACE (State or foreign country) <u>ROCKS MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL GEORGE BLANEY</u>		14. MOTHER'S MAIDEN NAME <u>MABEL I GLENN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-16-4453</u>	
17. INFORMANT <u>EDITH M. BLANEY</u>		Address <u>STREET MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA, ACUTE</u> 490X DUE TO (b) <u>M. TRAL STENOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>RHEUMATIC HEART Disease</u> 1 YEAR 25 YEARS			INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>57</u> , to <u>Oct 31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 1</u> , 19 <u>57</u> , and that death occurred at <u>SA</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>JARRETTVILLE, NOV 1st, 57</u> DATE SIGNED ACTUAL SIGNATURE <u>S. James Thomison, Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>S. JAMES THOMISON, JR. MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>NOV-4-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>1214 Cross Church</u>	22d. LOCATION (City, town, or county) (State) <u>Street Harford Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall K. Jarrett</u>		24a. REC'D BY REGISTRAR DATE <u>11 5:57</u>	24b. REGISTRAR'S SIGNATURE <u>Prunella Fourwood</u>

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 3

NOV 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11954

CERTIFICATE OF DEATH

11964

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b 31			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Battle Avenue				d. STREET ADDRESS Battle Avenue Gen. Del.			
3. NAME OF DECEASED (Type or print) First Ada Middle I Last Buchanan				4. DATE OF DEATH Month November Day 23 Year 19 57			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 April 1892	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Christy				14. MOTHER'S MAIDEN NAME Ella Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -- -- --		17. INFORMANT Dorothy Parker		Address Battle Avenue Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Cerebrovascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 8 days 5 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 11-12-57 , 19 57 , to 11-23-57 , 19 57 , that I last saw the deceased alive on 11-22-57 , 19 57 , and that death occurred at 1:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8 Law Street DATE SIGNED 11/25/57							
ACTUAL SIGNATURE Peter P. Rodman		M.D. Peter P. Rodman		ADDRESS (Street, city or town, state) 8 Law Street			
PHYSICIAN'S NAME (Type) Peter P. Rodman		M.D. M.D.		Aberdeen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/26/57	22c. NAME OF CEMETERY OR CREMATORY Union Methodist		22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring		ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE 11/26/57	24b. REGISTRAR'S SIGNATURE Mellie R. Perry		

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		PLACE OF BIRTH		DATE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED			
John G.	

RECEIVED
NOV 29 1957
BUREAU V. 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11965

11955

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAUCE DE GRACE				c. LENGTH OF STAY IN 1b 10 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FLORA Middle CAIN Last CAIN				4. DATE OF DEATH Month NOVEMBER Day 14 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown About 93	
9. AGE (In years last birthday) yrs. 93		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE CHEISTY				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. 187-10-7491		17. INFORMANT Address Eduard Cair, Harlington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) old Age 794x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 794x DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 mos to 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 1947, to Nov 14 , 1957, that I last saw the deceased alive on Nov 13 , 1957, and that death occurred at 6:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dudley Phillips MD M.D. Darlington Md				DATE SIGNED 11/14/57			
PHYSICIAN'S NAME (Type) Dudley Phillips				Darlington - Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Nov. 17, 1957		Hosanna Cem		Harford Co, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Bailey				ADDRESS Harlington Md		24a. REC'D BY REGISTRAR DATE Nov 16, 1957	
				24b. REGISTRAR'S SIGNATURE G. L. Lewis			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. 5

NOV 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11966

11970 CERTIFICATE OF DEATH

Reg. Dist. No.

187

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air Rural		c. LENGTH OF STAY IN 1b 1 yr., 4 mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Enos Middle N. Last Davis		4. DATE OF DEATH Month Nov. Day 27 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1970
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Home Construction	
11. BIRTHPLACE (State or foreign country) Fallston, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Enos R. Davis		14. MOTHER'S MAIDEN NAME Elizabeth A. Amos	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT J. Norman Davis		Address Abingdon Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic CV disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Bel Air, Md.		(County) (State)	
21. I certify that I attended the deceased from 8-1 , 19 57 , to 11-27 , 19 57 , that I last saw the deceased alive on 11-26 , 19 57 , and that death occurred at 9 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Gerald E Palmer		ADDRESS (Street, city or town, state) Bel Air, Md.	
PHYSICIAN'S NAME (Type) Gerald E Palmer M.D.		DATE SIGNED 11-30-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 1, 1957	22c. NAME OF CEMETERY OR CREMATORY Union Chapel	22d. LOCATION (City, town, or county) (State) Wilna, Harford, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Harold K. McCombs Jr.		ADDRESS Abingdon, Md.	24a. REC'D BY REGISTRAR DEC 3 1957
		24b. REGISTRAR'S SIGNATURE Trucella Forward	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		ORGAN OR SYSTEM		DISEASE OR INJURY		ORGAN OR SYSTEM		DISEASE OR INJURY		ORGAN OR SYSTEM	
10:00 PM		HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE		HEART		CORONARY ARTERY DISEASE		HEART		CORONARY ARTERY DISEASE		HEART	
PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		ORGAN OR SYSTEM		DISEASE OR INJURY		ORGAN OR SYSTEM		DISEASE OR INJURY		ORGAN OR SYSTEM	
10:00 PM		HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE		HEART		CORONARY ARTERY DISEASE		HEART		CORONARY ARTERY DISEASE		HEART	

BUREAU V. 2

DEC 4 1967

RECEIVED

11956

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 3,8,9 FilmG223 12-6-57 et

Reg. Dist. No.

185

FOR STATE
HEALTH DEPT.1. PLACE OF DEATH
a. COUNTY

Hartford

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE N.Y.

b. COUNTY

69X-3

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hartford Grace 10 minutes

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

New York - Whitehead St.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Hartford Memorial Hospital

d. STREET ADDRESS

1204 Rossmore Ave.

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒3. NAME OF DECEASED
(Type or print)

James Warren DeGraff

4. DATE OF DEATH

November 28 1957

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12/3/1917 1924

9. AGE (In years last birthday)

32 3/4 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Physicist

10b. KIND OF BUSINESS OR INDUSTRY

Unknown

11. BIRTHPLACE (State or foreign country)

Hempstead N.Y.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Cornelius De Graff

14. MOTHER'S MAIDEN NAME

Jennie Warren

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

U.S.A.

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

825X

DUE TO

Crushing injury Chest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Auto accident

20c. TIME OF INJURY

Month, Day, Year

Hour P.M.

11-28-57

20d. INJURY OCCURRED

While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Hartford Grace

20f. (City or town)

Hartford 7 Hartford

(County)

Md.

(State)

4. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Gerald E Palmer

M.D.

CHIEF MEDICAL EXAMINER ☐

Bel Air, Md.

DATE SIGNED

EXAMINER'S NAME (Type)

Gerald E Palmer

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

11-28-57

22a. BURIAL, CREMATION, REMOVAL (Specify)

Buried 12/2/57

22b. DATE THEREOF

St. Johns A.C.

22c. NAME OF CEMETERY OR CREMATORY

Whitehead St. N.Y.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

G. L. Lewis

ADDRESS

24a. REC'D BY REGISTRAR

DATE Nov 28-57

24b. REGISTRAR'S SIGNATURE

G. L. Lewis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 2 1957

BUREAU Y. R.

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
OFFICE OF EXAMINER: [illegible]

11971

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New Jersey b. COUNTY Union	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 2 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital		d. STREET ADDRESS 13 Tudor Court C/O Mack	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MYRTLE Middle Caskie Last DeMasse		4. DATE OF DEATH Month November Day 29 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 July 1900
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W Caskie		14. MOTHER'S MAIDEN NAME Ruhama Weston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Theodore E DeMasse		Address 7-C Jacobs Street Edgewood, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal carcinoma primary in large bowel DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized metastasis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 Days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 November, 19 57 , to 29 Nov , 19 57 , that I last saw the deceased alive on 19 , and that death occurred at 0830 a M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED US Army Hospital 29 Nov 57 Aberdeen Proving Ground, Md.			
ACTUAL SIGNATURE George C Santos		M.D.	
PHYSICIAN'S NAME (Type) George C Santos Capt MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Meyers, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Tanning		ADDRESS Aberdeen, Md.	
24a. REC'D BY REGISTRAR Nov 30-57		24b. REGISTRAR'S SIGNATURE Willie R Perry	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

File No. 100

Name of Deceased		Date of Death	
Place of Birth		Date of Birth	
Usual Residence		Place of Death	
Cause of Death		Manner of Death	
Occupation		Education	
Marital Status		Previous Illnesses	
Date of Admission to Hospital		Date of Discharge	
Name of Physician		Name of Hospital	
Signature of Physician		Signature of Registrar	

BUREAU V. 3

DEC 3 1957

RECEIVED

11969

11957

CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAYRE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAYRE DE GRACE</u>				24			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>803 LAFAYETTE ST.</u>				d. STREET ADDRESS <u>803 LAFAYETTE ST</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAURA BELLE DENNIS</u>				4. DATE OF DEATH Month Day Year <u>Nov. 27 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 19 1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM EDWARDS</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA CURTIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>MRS. ANNA ARMSTRONG 803 LAFAYETTE ST. HAYRE DE GRACE MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Slight mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 1956</u> to <u>Nov 27, 1957</u> , that I last saw the deceased alive on <u>11/20, 1957</u> , and that death occurred at <u>7:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>17 N. Philadelphia Blvd</u>				DATE SIGNED <u>11/27/57</u>			
PHYSICIAN'S NAME (Type) <u>F. V. Hatten</u>				<u>Abidee 2, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 30, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCK RUN, CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HARFORD MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>HAYRE DE GRACE MD.</u>				24a. REC'D BY REGISTRAR <u>DATE 11-30-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11970

11958

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>2 Years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Almshouse</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Washington</u> Middle <u>Evans</u> Last <u>Evans</u>		4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford County, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>March Evans</u>		14. MOTHER'S MAIDEN NAME <u>Susan Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Clinton Evans</u>		Address <u>Rocks, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Cardio-vascular Disease</u> (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 28, 1955</u> , to <u>November 28, 1957</u> , that I last saw the deceased alive on <u>November 25, 1957</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Maryland</u> <u>November 29, 1957</u>			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Maryland</u> <u>November 29, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 30, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Joy, Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Troyer Road, Balto. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion Smith</u>		24a. REC'D BY REGISTRAR <u>12-3-57</u>	
ADDRESS <u>Jarrettsville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Lownd</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11959

CERTIFICATE OF DEATH

11971
185

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>1 hr 5 min</u>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>		d. STREET ADDRESS <u>120 Liberty St</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Mem Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Boy Fleming</u>		4. DATE OF DEATH Month Day Year <u>Nov. 18 1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 18, 1957</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>10</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>		
13. FATHER'S NAME <u>Zane Donald Fleming</u>		14. MOTHER'S MAIDEN NAME <u>Patricia Buegrie</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		
17. INFORMANT Address <u>Hospital Records.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prematurity</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>11/18, 1957</u> , to <u>11/18, 1957</u> , that I last saw the deceased alive on <u>11/18, 1957</u> , and that death occurred at <u>10:55 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>17 N. Ph. 16 Rd.</u> DATE SIGNED <u>11/18/57</u>				
ACTUAL SIGNATURE <u>J. J. Hater</u>		M.D. <u>17 N. Ph. 16 Rd.</u>		
PHYSICIAN'S NAME (Type) <u>F. J. Hater</u>		<u>Aberdeen, Md.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11-18-57</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSPITAL</u>		22d. LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Ziegler Administrator</u>		3. ADDRESS		
24a. REC'D BY REGISTRAR <u>DATE 11-23-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		

2071253 XV7

CERTIFICATE OF DEATH

Form 2011, 1954

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>1912</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Engineer</i>		7. MARITAL STATUS <i>Married</i>		8. DECEASED AT HOME <input checked="" type="checkbox"/> <i>Yes</i>		9. DECEASED IN CARE OF <input type="checkbox"/> <i>No</i>		10. DECEASED IN HOSPITAL <input type="checkbox"/> <i>No</i>		11. DECEASED IN NURSING HOME <input type="checkbox"/> <i>No</i>		12. DECEASED IN OTHER PLACE <input type="checkbox"/> <i>No</i>	
13. DATE OF DEATH <i>Nov 20 1957</i>		14. TIME OF DEATH <i>10:30 AM</i>		15. PLACE OF DEATH <i>Home</i>		16. CAUSE OF DEATH <i>Myocardial Infarction</i>		17. MANNER OF DEATH <i>Natural</i>		18. MEDICAL HISTORY <i>None</i>		19. SURVIVAL <i>None</i>		20. SIGNATURE OF DECEASED <i>None</i>		21. SIGNATURE OF WITNESSES <i>None</i>		22. SIGNATURE OF DECEASED'S PHYSICIAN <i>None</i>		23. SIGNATURE OF DECEASED'S NEAREST RELATIVE <i>None</i>		24. SIGNATURE OF DECEASED'S NEXT OF KIN <i>None</i>	
25. SIGNATURE OF DECEASED'S PHYSICIAN <i>None</i>		26. SIGNATURE OF DECEASED'S NEAREST RELATIVE <i>None</i>		27. SIGNATURE OF DECEASED'S NEXT OF KIN <i>None</i>		28. SIGNATURE OF DECEASED'S NEXT OF KIN <i>None</i>		29. SIGNATURE OF DECEASED'S NEXT OF KIN <i>None</i>		30. SIGNATURE OF DECEASED'S NEXT OF KIN <i>None</i>		31. SIGNATURE OF DECEASED'S NEXT OF KIN <i>None</i>		32. SIGNATURE OF DECEASED'S NEXT OF KIN <i>None</i>		33. SIGNATURE OF DECEASED'S NEXT OF KIN <i>None</i>		34. SIGNATURE OF DECEASED'S NEXT OF KIN <i>None</i>		35. SIGNATURE OF DECEASED'S NEXT OF KIN <i>None</i>			

BUREAU V. S.

NOV 25 1957

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11972

11960 **CERTIFICATE OF DEATH**

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Hartford</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Hartford</u>
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>BEL AIR</u>	LENGTH OF STAY (in this place) <u>58 years</u>	CITY (If outside corporate limits, write RURAL end give nearest town) <u>BEL AIR</u>	TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>R</u> <u>Raymond</u> <u>Forwood</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov</u> <u>18</u> <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug 26-1886</u>
9. AGE last birthday <u>71</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STORE</u>	
11. BIRTHPLACE (State or foreign country) <u>Sandy Hook Hartford Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Lawrence Forwood</u>		14. MOTHER'S MAIDEN NAME <u>Jennie F Forwood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-10-7895</u>	
17. INFORMANT'S ADDRESS <u>M. E. S. B. H. Forwood</u> <u>BEL AIR MD</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>420.1</u> <u>CARDIO-RESP. FAILURE</u>			<u>45 MIN.</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>CORONARY OCCLUSION</u>			<u>14 HOURS.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work Not while at work	
22. I hereby certify that I attended the deceased from 19.53 to 18 Nov 19.57, that I last saw the deceased alive on 18 Nov 1957, and that death occurred at 9:45 P.M. from the causes and on the date stated above.			
SIGNATURE <u>J. H. Medwell</u>		DATE SIGNED <u>Nov 57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Nov 20/57</u>	
24. REC'D BY REGISTRAR <u>Prinella Forwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u>	
DATE <u>11-19-57</u>		ADDRESS (Street, city, town, state) <u>401 Parkview Rd Bel Air Md</u>	

CERTIFICATE OF DEATH

1. USUAL RESIDENCE (SHOW IF FOREIGN)

PLACE OF BIRTH

MARRIED

DATE OF DEATH

SEX

AGE

TIME OF DEATH

CAUSE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

PLACE

DATE

PLACE

BUREAU V. S.

NOV 21 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11961

CERTIFICATE OF DEATH

11973

Reg. Dist. No. 189

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 671 Andrews Road		d. STREET ADDRESS 671 Andrews Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle S. Last Gould		4. DATE OF DEATH Month November Day 28 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 October 1880
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Clerical	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Sprague		14. MOTHER'S MAIDEN NAME Carrie E. Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 126-22-4702	
17. INFORMANT Ruth R. Duffin		Address 671 Andrews Rd. Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO Carcinoma of lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lymphatic Leukemia		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October , 19 57 , to 11-28 , 19 57 , that I last saw the deceased alive on 11-22-57 , and that death occurred at 12:10 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 8 Law Street DATE SIGNED 11-29-57	
ACTUAL SIGNATURE Peter P. Rodman M.D.		ADDRESS Aberdeen, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/2/57	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John S. Jarring		ADDRESS Aberdeen, Md.	
24a. REG'D BY REGISTRAR 7/10/30/57		24b. REGISTRAR'S SIGNATURE Willie R. Perry	

RECEIVED

DEC 3 1957

BUREAU V. E.

Aberdeen, Md.

M.D.

Peter F. Rohman

Baltimore

Greenmount Cemetery

Interment

Aberdeen, Md.

1:10pm

No	186-32-4702	Birth R. Duffin	Aberdeen, Md.	671 Andrews Rd.
Secretary	Clerical	Mass.	U.S.A.	
Female	White	14 October 1880	71	
Elizabeth	S.	Gold	November 28	1927
671 Andrews Road				
Aberdeen				
Harford				

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11972

CERTIFICATE OF DEATH

11974

Reg. Dist. No. 182

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Forest Hill</u>				c. LENGTH OF STAY IN 1b <u>30 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Grier Nursery Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ursula</u> Last <u>Grafton</u>				4. DATE OF DEATH Month <u>November</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 22, 1872</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Grafton</u>				14. MOTHER'S MAIDEN NAME <u>Mary Varnes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>William G. Durham</u>		Address <u>Forest Hill, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Hypertensive Cardio-vascular Disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>15 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1942</u> , 19 <u> </u> , to <u>November 24, 1957</u> , that I last saw the deceased alive on <u>November 20</u> , 19 <u>57</u> , and that death occurred at <u>6:00A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city or town, state) <u>Forest Hill, Maryland</u>			
DATE SIGNED <u>November 25, 1957</u>							
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 26-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Brick Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Jarrettsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion S. Rust</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>11-27-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Privila Howard</u>			

REC 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11973 CERTIFICATE OF DEATH

Reg. Dist. No. 119752 1

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>New York</u> b. COUNTY <u>Suffolk</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampton Bays, Long Island</u> 69X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>US Army Hosp., Aberdeen Proving Ground</u>		d. STREET ADDRESS <u>Lynn Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Linda</u> Middle <u>Haberstroh</u> Last <u>Haberstroh</u>		4. DATE OF DEATH Month <u>November</u> Day <u>11</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 22, 1954</u>
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) <u>Augsburg, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Herbert L. Haberstroh</u>		14. MOTHER'S MAIDEN NAME <u>Thelma A. Mack</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Herbert L. Haberstroh</u>		Address <u>(Same as above)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronco-pneumonia Respiratory Failure</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>35 Hours</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November 10, 19 57</u> , to <u>November 11, 1957</u> , that I last saw the deceased alive on <u>November 11, 19 57</u> , and that death occurred at <u>1:51 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>William M. Michener</u> M.D.			
PHYSICIAN'S NAME (Type) <u>WILLIAM M. MICHENER, Capt, MC, US Army Hospital, Aberdeen Proving Ground, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>11/13/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bronx, New York</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		ADDRESS <u>Aberdeen, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>Nov. 13-57</u>
		24b. REGISTRAR'S SIGNATURE <u>W. Ellis R. Perry</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES M. SMITH		45		M		W		JAN 15 1880		BALTIMORE, MD	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JUN 10 1905		BALTIMORE, MD		MARY E. SMITH		NOV 10 1957		BALTIMORE, MD	
OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT	
LABORER		NOV 10 1957		BALTIMORE, MD		HEART DISEASE		NATURAL		DR. J. H. SMITH	
EDUCATION		DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF CEMETERY		DATE OF BURIAL		NAME OF MINISTER	
HIGH SCHOOL		NOV 12 1957		BALTIMORE, MD		GREENWOOD CEMETERY		NOV 12 1957		REV. J. H. SMITH	
RELIGION		DATE OF REPORT		PLACE OF REPORT		NAME OF REPORTER		DATE OF SIGNATURE		NAME OF SIGNATURE	
CATHOLIC		NOV 10 1957		BALTIMORE, MD		J. H. SMITH		NOV 10 1957		J. H. SMITH	

BUREAU V. S.

NOV 18 1957

RECEIVED

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES M. SMITH		45		M		W		JAN 15 1880		BALTIMORE, MD	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JUN 10 1905		BALTIMORE, MD		MARY E. SMITH		NOV 10 1957		BALTIMORE, MD	
OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT	
LABORER		NOV 10 1957		BALTIMORE, MD		HEART DISEASE		NATURAL		DR. J. H. SMITH	
EDUCATION		DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF CEMETERY		DATE OF BURIAL		NAME OF MINISTER	
HIGH SCHOOL		NOV 12 1957		BALTIMORE, MD		GREENWOOD CEMETERY		NOV 12 1957		REV. J. H. SMITH	
RELIGION		DATE OF REPORT		PLACE OF REPORT		NAME OF REPORTER		DATE OF SIGNATURE		NAME OF SIGNATURE	
CATHOLIC		NOV 10 1957		BALTIMORE, MD		J. H. SMITH		NOV 10 1957		J. H. SMITH	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11974 CERTIFICATE OF DEATH

11976
 Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Kalmia</u>				c. LENGTH OF STAY IN 1b <u>1 year</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>C.</u> Last <u>Harkins</u>				4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 1, 1883</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>74</u> Days <u>74</u> Hours <u>74</u> Min. <u>74</u>		IF UNDER 24 HRS. Months <u>74</u> Days <u>74</u> Hours <u>74</u> Min. <u>74</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John F. Smithson</u>				14. MOTHER'S MAIDEN NAME <u>Johanna Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Charles Michael, Bel Air, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Disease</u> DUE TO 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>7</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. j. p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>November</u> , 19 <u>56</u> , to <u>November 20</u> 19 <u>57</u> , that I last saw the deceased alive on <u>November 19</u> 19 <u>57</u> , and that death occurred at <u>9:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Maryland</u> <u>Nov. 21, 1957</u> PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 23, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CENTRE METHODIST CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>FOREST HILL, HARF. CO., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>				ADDRESS <u>BEL AIR, MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>11-21-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Russella Foward</u>			

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11962

CERTIFICATE OF DEATH

11977

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Green</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William E. Williams</u> First Middle Last				4. DATE OF DEATH <u>November 26</u> Month Day Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/4/81</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Charles Williams</u>			
14. MOTHER'S MAIDEN NAME <u>Sidney Norris</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>212-14-8398</u>				17. INFORMANT <u>Myrtle M. Harward</u> Address <u>Abingdon Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomalacia</u> DUE TO <u>332x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Vascular Thrombosis</u> DUE TO <u>20 days.</u> (c) <u>Generalized arteriosclerosis</u> DUE TO <u>?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493x</u> <u>Terminal Pneumonia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov. 6th</u> , 19 <u>57</u> , to <u>Nov. 26th</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 26th</u> , 19 <u>57</u> , and that death occurred at <u>7:30 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Loo</u> M.D.				ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Abingdon, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				DATE SIGNED <u>11/26/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 30, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCombs Jr.</u>				ADDRESS <u>Abingdon, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 3 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. A. L. Lewis</u>			

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

See back for instructions

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
MARRIED		JANUARY 1, 1960		MEMPHIS, TENNESSEE	
EDUCATION		DATE OF EDUCATION		PLACE OF EDUCATION	
HIGH SCHOOL		1955		MEMPHIS, TENNESSEE	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION	
CONTRACTOR		1960		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH	
HEART DISEASE		APRIL 4, 1968		MEMPHIS, TENNESSEE	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH	
NATURAL		APRIL 4, 1968		MEMPHIS, TENNESSEE	
CERTIFICATE OF DEATH		DATE OF CERTIFICATE OF DEATH		PLACE OF CERTIFICATE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
MARRIED		JANUARY 1, 1960		MEMPHIS, TENNESSEE	
EDUCATION		DATE OF EDUCATION		PLACE OF EDUCATION	
HIGH SCHOOL		1955		MEMPHIS, TENNESSEE	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION	
CONTRACTOR		1960		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH	
HEART DISEASE		APRIL 4, 1968		MEMPHIS, TENNESSEE	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH	
NATURAL		APRIL 4, 1968		MEMPHIS, TENNESSEE	
CERTIFICATE OF DEATH		DATE OF CERTIFICATE OF DEATH		PLACE OF CERTIFICATE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE	

BUREAU V. 8

DEC 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11978

11963 CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harre-de-Grace		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy A Heaps		4. DATE OF DEATH 11 17 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) new born		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mason Crel Heaps		14. MOTHER'S MAIDEN NAME Norabell Heaps	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mason Crel Heaps		Address Edgewood Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 760.5 Intracerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adrenal gland hemorrhage (c) Prematurity (34 wks gestation) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/6 , 19 57 , to 11/17 , 19 57 , that I last saw the deceased alive on 11/17 , 19 57 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE F. J. Hatem		ADDRESS (Street, city or town, state) 17 N. Phila. Rd. Aberdeen, Md.	
PHYSICIAN'S NAME (Type) F. J. Hatem		DATE SIGNED 11/18/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 19, 1957	22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	22d. LOCATION (City, town, or county) (State) Bel Air, Harford, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McEwen		24a. REC'D BY REGISTRAR DATE 25 1957	
ADDRESS Abingdon Maryland.		24b. REGISTRAR'S SIGNATURE A. L. Lewis	

2171202XV2

BUREAU V. S.

NOV 25 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11979

: 11975

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural</u> <u>Bel Air</u>		LENGTH OF STAY (in this place) <u>5 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Havre de Grace</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford County Home</u>				STREET ADDRESS (If rural give location) <u>4 Clair & Market</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Joseph</u>		(Middle) <u>N.</u>		(Last) <u>Hergenrother</u>		(Month) <u>Nov.</u> (Day) <u>7</u> (Year) <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>October 27, 1885</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph A. Hergenrother</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Weber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Rock Hergenrother, Havre de Grace, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>Sudden</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Cardio-vascular Disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 25</u> , 19 <u>52</u> , to <u>Nov. 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 3</u> , 19 <u>57</u> , and that death occurred at <u>11:45 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u> DATE SIGNED <u>Nov. 7, 1957</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11/11/57</u>		NAME OF CEMETERY OR CREMATORY <u>St. Ann</u>		LOCATION (City, town, or county) (State) <u>Havre de Grace, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>11-11-57</u>		REGISTRAR'S SIGNATURE <u>G. L. Davis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Hargrett</u>		ADDRESS <u>Havre de Grace, Md.</u>	

RECEIVED

11964 CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b 31 Aberdeen			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First George Middle W. Last Homer				4. DATE OF DEATH Month November Day 16 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 July 1868	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Vincent Homer				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -- --		17. INFORMANT Viola Tuttle Address R.D. 2 Havre de Grace, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Influenza DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 week 1 month							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11-16-57 to 11-16-57 , that I lost sow the deceased alive on 11-16-57 , and that death occurred at 1:30 PM , from the causes ond on the date stoted above. ADDRESS (Street, City or town, state) 8 W St. Aberdeen, Md. DATE SIGNED 11-16-57							
ACTUAL SIGNATURE P. P. Rodman M.D.				PHYSICIAN'S NAME (Type) P. P. Rodman M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/18/57		22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery	
22d. LOCATION (City, town, or county) (State) R.D. 2 Aberdeen, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR Nov. 18-57	
24b. REGISTRAR'S SIGNATURE Nellie R Perry							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
JAMES J. HARRIS		35		Male		White		November 22, 1957		Boston, Massachusetts	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Previous Illnesses	
Myocardial Infarction		Natural		Carpenter		High School		Married		None	
Physician's Signature		Hospital		City		State		County		District	
[Signature]		St. Vincent's Hospital		Boston		Massachusetts		Suffolk		North	
Registrar's Signature		Date of Registration		City		State		County		District	
[Signature]		November 28, 1957		Boston		Massachusetts		Suffolk		North	

BUREAU OF VITALS

NOV 22 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11965 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Filing 223 12-12-57 et

Reg. Dist. No.

11985
185

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford & Grace</u> c. LENGTH OF STAY IN 1b <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air, Md.</u> d. STREET ADDRESS <u>Thomas Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard Lee Houck</u> First Middle Last 4. DATE OF DEATH <u>November 22 19 57</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan 26 1912</u> 9. AGE (In years last birthday) <u>46 yrs.</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Repair</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Glenn L. Martineau Todd, Inc.</u> 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Joseph T Houck</u> 14. MOTHER'S MAIDEN NAME <u>Bettie Scott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>217-16-1161</u> 17. INFORMANT <u>Mrs Helen M. Houck</u> Address <u>Thomas St Bel Air</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>816X</u> DUE TO <u>Crushing injury chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crushing injury chest</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Auto accident</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto-object type</u>		20c. TIME OF INJURY Month, Day, Year <u>Nov 16 57</u> Hour <u>11:30</u> a.m. <u>NOV 16 57</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 22</u> 20f. (City or town) <u>Aberdeen</u> (County) <u>Hartford</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Nov 25 57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Wm Walters</u> 22d. LOCATION (City, town, or county) (State) <u>Georgetown, Hartford, Md</u>		24a. REC'D BY REGISTRAR <u>DEC 2 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Dr. U. L. Lewis</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin Skuck</u> ADDRESS <u>Sancti...</u>			

1954

BUREAU V. 5

DEC 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11976

CERTIFICATE OF DEATH

11982

Reg. Dist. No. 182

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-DARLINGTON				c. LENGTH OF STAY IN 1b 11 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 RURAL-DARLINGTON			
				d. STREET ADDRESS			
				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ARTHUR Middle IDDINGS Last IDDINGS				4. DATE OF DEATH Month Nov. Day 24 Year 1957			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 23, 1891	
				9. AGE (In years (at birthday) yrs. 66		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM OWNER				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) HANOVER, INDIANA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHARLES IDDINGS				14. MOTHER'S MAIDEN NAME MATTIE WILSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) YES WWI				16. SOCIAL SECURITY NO. 213-38-9408A			
17. INFORMANT MRS. ARTHUR IDDINGS, DARLINGTON, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 MINUTE	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
					20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from MAY 1949 , to NOV 24 , 1957, that I last saw the deceased alive on NOV 18 , 1957, and that death occurred at 1 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Darlington, Md DATE SIGNED 11/24/57							
ACTUAL SIGNATURE Dudley Phillips MD M.D. Darlington, Md				PHYSICIAN'S NAME (Type) Dudley Phillips MD DARLINGTON, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 11-24-1957		22c. NAME OF CEMETERY OR CREMATORY U. OF MD. MEDICAL SCHOOL		22d. LOCATION (City, town, & county) (State) BALTIMORE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins, Delta, Pa.				ADDRESS		24a. REC'D BY REGISTRAR DATE 11-26-57	
				24b. REGISTRAR'S SIGNATURE Phyllis Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

107 68 NON

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11966

CERTIFICATE OF DEATH

11983

Reg. Dist. No.

155

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>Box 26 H</u>			
3. NAME OF DECEASED (Type or print) <u>Rose</u> First <u>Shuman</u> Middle <u>Shuman</u> Last				4. DATE OF DEATH <u>Nov 10</u> 19 <u>57</u> Month Day Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/1/05</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Harford Memorial Hospital Records</u> Address <u>Harford de Grace</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Hypertensive-Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11/5</u> , 19 <u>57</u> , to <u>11/10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/10</u> , 19 <u>57</u> , and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George T. Stansbury</u> M.D.				ADDRESS (Street, city or town, state) <u>569 Revolution St, Harford de Grace, Md.</u> DATE SIGNED <u>11/10/57</u>			
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				<u>Harford de Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-14-1957</u>		<u>Jones Memorial</u>		<u>Port Deposit, Md. Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. A. Patterson & Son, Perryville, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>11-14-57</u>		<u>G. L. Dennis, Md.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. NAME OF PHYSICIAN		13. SIGNATURE OF PHYSICIAN		14. NAME OF MINISTER OF RELIGION		15. SIGNATURE OF MINISTER	
16. NAME OF CORONER		17. SIGNATURE OF CORONER		18. NAME OF JURY		19. SIGNATURE OF JURY		20. NAME OF WITNESSES	
21. SIGNATURE OF WITNESSES		22. NAME OF WITNESSES		23. SIGNATURE OF WITNESSES		24. NAME OF WITNESSES		25. SIGNATURE OF WITNESSES	
26. NAME OF WITNESSES		27. SIGNATURE OF WITNESSES		28. NAME OF WITNESSES		29. SIGNATURE OF WITNESSES		30. NAME OF WITNESSES	
31. SIGNATURE OF WITNESSES		32. NAME OF WITNESSES		33. SIGNATURE OF WITNESSES		34. NAME OF WITNESSES		35. SIGNATURE OF WITNESSES	
36. NAME OF WITNESSES		37. SIGNATURE OF WITNESSES		38. NAME OF WITNESSES		39. SIGNATURE OF WITNESSES		40. NAME OF WITNESSES	
41. SIGNATURE OF WITNESSES		42. NAME OF WITNESSES		43. SIGNATURE OF WITNESSES		44. NAME OF WITNESSES		45. SIGNATURE OF WITNESSES	
46. NAME OF WITNESSES		47. SIGNATURE OF WITNESSES		48. NAME OF WITNESSES		49. SIGNATURE OF WITNESSES		50. NAME OF WITNESSES	
51. SIGNATURE OF WITNESSES		52. NAME OF WITNESSES		53. SIGNATURE OF WITNESSES		54. NAME OF WITNESSES		55. SIGNATURE OF WITNESSES	
56. NAME OF WITNESSES		57. SIGNATURE OF WITNESSES		58. NAME OF WITNESSES		59. SIGNATURE OF WITNESSES		60. NAME OF WITNESSES	
61. SIGNATURE OF WITNESSES		62. NAME OF WITNESSES		63. SIGNATURE OF WITNESSES		64. NAME OF WITNESSES		65. SIGNATURE OF WITNESSES	
66. NAME OF WITNESSES		67. SIGNATURE OF WITNESSES		68. NAME OF WITNESSES		69. SIGNATURE OF WITNESSES		70. NAME OF WITNESSES	
71. SIGNATURE OF WITNESSES		72. NAME OF WITNESSES		73. SIGNATURE OF WITNESSES		74. NAME OF WITNESSES		75. SIGNATURE OF WITNESSES	
76. NAME OF WITNESSES		77. SIGNATURE OF WITNESSES		78. NAME OF WITNESSES		79. SIGNATURE OF WITNESSES		80. NAME OF WITNESSES	
81. SIGNATURE OF WITNESSES		82. NAME OF WITNESSES		83. SIGNATURE OF WITNESSES		84. NAME OF WITNESSES		85. SIGNATURE OF WITNESSES	
86. NAME OF WITNESSES		87. SIGNATURE OF WITNESSES		88. NAME OF WITNESSES		89. SIGNATURE OF WITNESSES		90. NAME OF WITNESSES	
91. SIGNATURE OF WITNESSES		92. NAME OF WITNESSES		93. SIGNATURE OF WITNESSES		94. NAME OF WITNESSES		95. SIGNATURE OF WITNESSES	
96. NAME OF WITNESSES		97. SIGNATURE OF WITNESSES		98. NAME OF WITNESSES		99. SIGNATURE OF WITNESSES		100. NAME OF WITNESSES	

RECEIVED
NOV 15 1907
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11977 CERTIFICATE OF DEATH

Reg. Dist. No. 11984
182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harlington</u>		c. LENGTH OF STAY IN 1b <u>0</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Whitford Harlington</u>	
3. NAME OF DECEASED (Type or print) <u>Hella</u> First <u>R</u> Middle <u>Lawson</u> Last		4. DATE OF DEATH <u>Nov. 17</u> Month <u>1957</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>Dec. 3, 1891</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>	11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md., U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Cain</u>	
14. MOTHER'S MAIDEN NAME <u>Georgina Parker</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u>	
16. SOCIAL SECURITY NO. <u>215-32-0809</u>		17. INFORMANT <u>Richard Cain</u> Address <u>Harlington</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Attack</u> 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Unknown</u> DUE TO (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Unknown</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 17</u> , 19 <u>57</u> , to <u>Nov 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 17</u> , 19 <u>57</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F.P. Snodgrass</u>		ADDRESS (Street, city or town, state) <u>Warehington Md</u>	
DATE SIGNED <u>Nov 18, 1957</u>		DATE SIGNED <u>C.D. Kirk</u>	
PHYSICIAN'S NAME (Type) <u>F.P. Snodgrass M.D.</u>		PHYSICIAN'S NAME (Type) <u>F.P. Snodgrass M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 21, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Assanna Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Bailey</u>		24a. REC'D BY REGISTRAR <u>Nov 18, 1957</u>	
ADDRESS <u>Harlington, Md</u>		24b. REGISTRAR'S SIGNATURE <u>C.D. Kirk</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text and stamps on the certificate form]

BUREAU V. S.

NOV 29 1957

RECEIVED

11978

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Darlington</i>		c. LENGTH OF STAY IN 1b <i>x2 Whiteford</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>Leslie Hamilton Little</i>		4. DATE OF DEATH <i>November 17 1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>June 13, 1924</i> 33 yrs.
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Kenneth Little</i>		14. MOTHER'S MAIDEN NAME <i>Anna M. Henry</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>219-18-0381</i>	
17. INFORMANT <i>Kenneth Little</i>		Address <i>Whiteford Harford Co. Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture Skull</i> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Whiteford</i> (c) <i>Harford Co. Md.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident, auto auto type</i>	
20c. TIME OF INJURY Month, Day, Year <i>11-17-57</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Conowago Dam</i>	20f. (City or town) (County) (State) <i>Conowago Harford Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Harford County</i> DATE SIGNED <i>11-17-57</i>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <i>Bel Air Md</i>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify)	22b. DATE THEREOF <i>Nov 20, 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Tabernacle Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Harford Co. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. S. Bailey</i>		24a. REC'D BY REGISTRAR <i>Nov 18, 1957</i> 24b. REGISTRAR'S SIGNATURE <i>C. H. Kirk</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FIRST

STATE OF MARYLAND
COUNTY OF

THIS CERTIFICATE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

HEIGHT

WEIGHT

HAIR

EYES

SKIN

TEETH

NOSE

EARS

THROAT

NECK

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

UTERUS

VAGINA

TESTES

PROSTATE

<

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11979 CERTIFICATE OF DEATH

Reg. Dist. No. 11985

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PYLESVILLE		c. LENGTH OF STAY IN 1b 69 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LUTHER MARTIN LOWE		4. DATE OF DEATH 11-17-1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-1-1888
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER + INSURANCE AGENT		10b. KIND OF BUSINESS OR INDUSTRY INSURANCE AGENT	
11. BIRTHPLACE (State or foreign country) HARFORD Co. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LABAN LOWE		14. MOTHER'S MAIDEN NAME MARGARET TAYLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 218-05-2249	
17. INFORMANT William B. Same Fawn Grove Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 17 , 19 57 , to Nov 17 , 19 57 , that I last saw the deceased alive on Nov 17 , 19 57 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fawn Grove Pa. DATE SIGNED Nov 17, 1957			
ACTUAL SIGNATURE Edward W. Hyson M.D.		PHYSICIAN'S NAME (Type) Edward W. Hyson	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-19-57	
22c. NAME OF CEMETERY OR CREMATORY FAWN GROVE METH.		22d. LOCATION (City, town, or county) (State) FAWN GROVE, YORK CO. PA.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth C. Chubb ADDRESS Stewartstown Pa.		24a. REC'D BY REGISTRAR 11/19/57 24b. REGISTRAR'S SIGNATURE Barbara Lownd	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11980 CERTIFICATE OF DEATH

11987

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Bel Air</u>		c. LENGTH OF STAY IN 1b <u>1 Month</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescent Home</u>		1 d. STREET ADDRESS <u>220 Otsego Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>R.</u> Last <u>McFadden</u>		4. DATE OF DEATH Month <u>November</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>January 4, 1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hochschild Mabel</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Sheridan</u>		14. MOTHER'S MAIDEN NAME <u>Betsey Callion</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Unknown</u>	
17. INFORMANT <u>Mr. Helen R. Denham</u>		Address <u>820 Otsego St. Harford Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Cardio-vascular Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 11</u> , 1957, to <u>Nov. 7</u> , 1957, that I last saw the deceased alive on <u>Nov. 6</u> , 1957, and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.		ADDRESS (Street, city or town, state) <u>Forest Hill, Maryland</u> DATE SIGNED <u>November 8, 1957</u>	
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>		<u>Forest Hill, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11/11/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodland</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Hurd</u>		ADDRESS <u>Harford Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>11-11-57</u>		24b. REGISTRAR'S SIGNATURE <u>B. L. Lewis m.d.</u>	

BUREAU V. S.

NOV 12 1957

RECEIVED

11981

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "At his home"				d. STREET ADDRESS Morse Mill Rd. (Near Cooptown)			
3. NAME OF DECEASED (Type or print) First Harry Middle Linwood Last Morse				4. DATE OF DEATH Month November Day 15 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1878		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 9 Days 13	IF UNDER 24 HRS. Hours 13 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawmill		10b. KIND OF BUSINESS OR INDUSTRY Cooptown		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Morse				14. MOTHER'S MAIDEN NAME Laura Jane Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT George Walter Morse, Forest Hill			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction of unknown etiology 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Prostatism with urinary retention							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-25-57 , 19____, to 11-15-57 , 19____, that I last saw the deceased alive on Nov. 15, 19 57 , and that death occurred at 6:00AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED 11/16/57							
ACTUAL SIGNATURE Willard P. Hudson							
PHYSICIAN'S NAME (Type) WILLARD P. HUDSON, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 17-57		22c. NAME OF CEMETERY OR CREMATORY Wm. Walters		22d. LOCATION (City, town, or county) (State) Cooptown Harford Md	
23. FUNERAL DIRECTOR'S SIGNATURE William King				ADDRESS James M. King		24a. REC'D BY REGISTRAR DATE 11/19-57	
						24b. REGISTRAR'S SIGNATURE Priscilla Toward	

BUREAU V. S.

NOV 18 1957

RECEIVED

11982

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Connecticut b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b No Time	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US ARMY HOSPITAL ABERDEEN PROVING GROUND, MARYLAND		d. STREET ADDRESS Mead Lane	
3. NAME OF DECEASED (Type or print) First Jonathan Middle Last Peterson		4. DATE OF DEATH Month November Day 30 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 June 1933
9. AGE (In years last birthday) 24 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY US Army	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Jonathan W. Peterson		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 263-56-8815	
17. INFORMANT Jonathan W. Peterson		Address Greenwich Connecticut	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Shock DUE TO 816x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intraperitoneal Hemorrhagic DUE TO (c) Multiple Lacerations of Spleen and Liver PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Laceration upper lip & chin, nasal rigidity, ecchymotic area, left of sternum abdomen. Compound fracture right femur			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) ran under left rear end of tractor trailer truck			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 0350 a. m. Nov 30 19 57	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) US Route 40	
20f. (City or town) Loreley Hill near		(County) (State) Allender Road Baltimore Md	
21. I certify that I attended the deceased from 5:00 AM 30 Nov 57 to 5:15 AM 30 Nov 57 , that I last saw the deceased alive on 5:12 AM 30 Nov 1957 , and that death occurred at 5:15 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Alexander A. Klos, Capt, MC		ADDRESS (Street, city or town, state) US ARMY HOSPITAL ABERDEEN PROVING GROUND, MD	
DATE SIGNED 30 Nov 57			
22a. NAME OF CEMETERY OR CREMATORY Knap Funeral Home		22b. DATE THEREOF 12/2/57	
22c. LOCATION (City, town or county) Greenwich Connecticut		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Earl B. Woberton Funeral Home, Inc			
ADDRESS 6306-Belair Rd, Baltimore - Bgmd		24a. REC'D BY REGISTRAR DEC 3 1957	
24b. REGISTRAR'S SIGNATURE Willie Perry			

CERTIFICATE OF DEATH

DEATH OF A NATURAL PERSON (For deaths occurring in the State of Maryland)		DEATH OF A NON-NATURAL PERSON (For deaths occurring in the State of Maryland)	
NAME OF DECEASED [REDACTED]		NAME OF DECEASED [REDACTED]	
SEX [REDACTED]		SEX [REDACTED]	
AGE [REDACTED]		AGE [REDACTED]	
DATE OF BIRTH [REDACTED]		DATE OF BIRTH [REDACTED]	
PLACE OF BIRTH [REDACTED]		PLACE OF BIRTH [REDACTED]	
OCCUPATION [REDACTED]		OCCUPATION [REDACTED]	
CAUSE OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]	
MANNER OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
DATE OF DEATH [REDACTED]		DATE OF DEATH [REDACTED]	
PLACE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF DECEASED [REDACTED]	
SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF WITNESS [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]	
SIGNATURE OF CORONER [REDACTED]		SIGNATURE OF CORONER [REDACTED]	
SIGNATURE OF JUDGE [REDACTED]		SIGNATURE OF JUDGE [REDACTED]	
SIGNATURE OF CLERK [REDACTED]		SIGNATURE OF CLERK [REDACTED]	

BUREAU V. B.

DEC 3 1957

RECEIVED

BUREAU V. S.

NOV 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11983

CERTIFICATE OF DEATH

11991

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen, Rural				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #1				d. STREET ADDRESS Route #1			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Sarah Middle Jane Last Robinson				4. DATE OF DEATH Month November Day 28 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 May 1864	
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME David Yontz				14. MOTHER'S MAIDEN NAME Delia Cornett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -- --		17. INFORMANT Mrs. Clay Robinson Address Route #1 Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CV Disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 days 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 1940 to April 1957 , that I last saw the deceased alive on Nov 27, 1957 , and that death occurred at 2:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Churchville DATE SIGNED Nov 28							
ACTUAL SIGNATURE J. Ralph Horky M.D.				PHYSICIAN'S NAME (Type) J. Ralph Horky M.D. Churchville, Md. 28 Nov. 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11/29/57		22c. NAME OF CEMETERY OR CREMATORY Comers Rock Cemetery		22d. LOCATION (City, town, or county) (State) Comers Rock Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John S. Farring ADDRESS Aberdeen, Md.				24a. REC'D BY REGISTRAR Nov 29/57		24b. REGISTRAR'S SIGNATURE Hellie R Perry	

CERTIFICATE OF DEATH

Name of Deceased James H. Robinson		Age 35		Sex Male		Race White		Marital Status Married		Date of Death May 18, 1951		Place of Death House 21	
Residence House 21		City Aberdeen		County Harford		State Maryland		Country U.S.A.		Date of Birth May 2, 1916		Place of Birth House 21	
Name of Informant Mrs. Mary Robinson		Relationship Wife		Address House 21		City Aberdeen		County Harford		State Maryland		Country U.S.A.	
Signature of Informant [Signature]		Signature of Physician [Signature]		Signature of Coroner [Signature]		Signature of Registrar [Signature]		Signature of Burial Officer [Signature]		Signature of Undertaker [Signature]		Signature of Funeral Home [Signature]	
Cause of Death [Blank]		Immediate Cause [Blank]		Underlying Cause [Blank]		Manner of Death [Blank]		Place of Burial [Blank]		Date of Burial [Blank]		Place of Burial [Blank]	
Date of Death May 18, 1951		Time of Death [Blank]		Place of Death House 21		City Aberdeen		County Harford		State Maryland		Country U.S.A.	
Name of Informant Mrs. Mary Robinson		Relationship Wife		Address House 21		City Aberdeen		County Harford		State Maryland		Country U.S.A.	
Signature of Informant [Signature]		Signature of Physician [Signature]		Signature of Coroner [Signature]		Signature of Registrar [Signature]		Signature of Burial Officer [Signature]		Signature of Undertaker [Signature]		Signature of Funeral Home [Signature]	

BUREAU V. 2

DEC 3 1951

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11968

CERTIFICATE OF DEATH

11992

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>ROUTE #2</u>	
3. NAME OF DECEASED (Type or print) First <u>CHINTON</u> Middle <u>RUSH</u> Last <u>RUSH</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May, 13, 1917</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHEMICAL OPERATOR</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Chemical</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME (Print) <u>ANDREW JACKSON RUSH</u>	
14. MOTHER'S MAIDEN NAME <u>SUSIE FRANCES WIDNER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>225-18-9966</u>		17. INFORMANT Address <u>DOROTHY RUSH HAURE DE GRACE RT.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>60 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> , 19 <u>50</u> , to <u>Nov 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 2</u> , 19 <u>57</u> , and that death occurred at <u>2:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips</u>		ADDRESS (Street, city or town, state) <u>Darlington, Md</u> DATE SIGNED <u>11/3/57</u>	
PHYSICIAN'S NAME (Type) <u>Darlington, Md</u>		Dudley Phillips <u>Darlington Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 5, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCombs Jr</u>		ADDRESS <u>Abingdon Maryland.</u>	24a. REC'D BY REGISTRAR <u>NOV 7 1957</u>
		24b. REGISTRAR'S SIGNATURE <u>Dr. L. L. Lewis</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
MIDDLE NAME		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIED		SINGLE		WIDOWED		DIVORCED		SEPARATED		OTHER	
OCCUPATION		EDUCATION		RELIGION		MILITARY SERVICE		CIVIL SERVICE		OTHER	
CAUSE OF DEATH		MANNER OF DEATH		IMMEDIATE CAUSE		INTERMEDIATE CAUSE		UNDERLYING CAUSE		OTHER	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	

BUREAU V. S.

NOV 2 1967

RECEIVED

11984

CERTIFICATE OF DEATH

11993

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PA. b. COUNTY YORK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITEFORD				c. LENGTH OF STAY IN 1b 5WKS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DELTA 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last HOWARD ELLSWORTH SINGLETON				4. DATE OF DEATH Month Day Year Nov. 17, 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 2, 1895		9. AGE (In years last birthday) 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOVEL OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY SLATE		11. BIRTHPLACE (State or foreign country) YORK Co., PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM H. SINGLETON				14. MOTHER'S MAIDEN NAME EMMA GUYTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 182-01-1375		17. INFORMANT Address EMMA KEESEE, WHITEFORD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cardiac Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Art. Sclerotic C-V Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 57 , to Nov 17 , 19 57 , that I last saw the deceased alive on Nov 17 , 19 57 , and that death occurred at 7:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Delta Pa. DATE SIGNED 11/19/57							
ACTUAL SIGNATURE Josiah A Hunt M.D.				DATE SIGNED 11/19/57			
PHYSICIAN'S NAME (Type) Josiah A Hunt MD				ADDRESS Delta Pa.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-20-1957		22c. NAME OF CEMETERY OR CREMATORY MT. NEBO		22d. LOCATION (City, town, or county) (State) DELTA, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Haskins, Delta, Pa.				24a. REC'D BY REGISTRAR DATE 11-21-57		24b. REGISTRAR'S SIGNATURE Priscilla Howard	

MEDICAL CERTIFICATION

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

See Div. 10

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

BUREAU V. 1

NOV 22 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11985

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11994

Items 8, 9 Film G223 12-2-57 et

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RDI</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sarah Elizabeth Trusty</u>		4. DATE OF DEATH <u>November 20 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 13 1868</u>
9. AGE (In years last birthday) <u>75-84 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Med</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Benson</u>		14. MOTHER'S MAIDEN NAME <u>Sidney Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	
17. INFORMANT <u>Frances Pease</u>		Address <u>Bel Air MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic CV disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 23 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Clarks Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>KALMIA, Harf. Co., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T Foster Bel Air Md</u>		24a. REC'D BY REGISTRAR <u>11-21-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Pruitt Howard</u>			

RECEIVED

NOV 23 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY in 1b <u>12 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>162 E Broadway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marie M. W. Evans</u>		4. DATE OF DEATH <u>November 6 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 15-1862</u>
9. AGE (In years last birthday) <u>95</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GERMANY</u>	
11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>Natural</u>	
13. FATHER'S NAME <u>John Gatzmann</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Schantz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>James McKeon</u> Address <u>62 E Broadway Bel Air Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bruise R Chest</u> 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis generalized</u> (b) <u>Infection</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell against radiator</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-28-57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Bel Air Md</u> (County) <u>md</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-6-57</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Zion</u>		22d. LOCATION (City, town, or county) <u>Fountain Green Harford Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph K. Bel Air Md</u> ADDRESS		24a. REC'D BY REGISTRAR <u>11-7-57</u> 24b. REGISTRAR'S SIGNATURE <u>Purcella Foxwood</u>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 30
1966 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 5

NOV 12 1957

RECEIVED